Sullivan County Community Hospital

Sullivan, Indiana

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution February 18, 2020[1]

SULLIVAN COUNTY
COMMUNITY HOSPITAL

Dear Community Member:

At Sullivan County Community Hospital, we have spent more than 100 years providing high-quality compassionate healthcare to the greater Sullivan community. The “2019 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Sullivan County Community Hospital (SCCH) will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

SCCH will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together, we can make our community healthier for every one of us.

Thank You,

Michelle Franklin
Chief Executive Officer
Sullivan County Community Hospital

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EXECUTIVE SUMMARY

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Sullivan County Community Hospital ("SCCH" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. Additionally, the group reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The 2019 Significant Health Needs identified for Sullivan County are:

1. Cancer
2. Obesity/Overweight – 2016 Significant Need
3. Diabetes – 2016 Significant Need
4. Drug/Substance Abuse – 2016 Significant Need
5. Heart Disease – 2016 Significant Need
6. Mental Health
7. Physical Inactivity – 2016 Significant Need
8. Education/Prevention

The Hospital has developed implementation strategies for five of the eight health needs (Cancer, Obesity/Overweight, Diabetes, Drug/Substance Abuse, and Physical Inactivity) including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all 501(c)(3) hospitals as a condition of retaining tax-exempt status. ***While Sullivan County Community Hospital ("SCCH" or "the Hospital") is not a 501(c)(3) hospital, this study is designed to comply with the same standards and helps assure SCCH identifies and responds to the primary health needs of its residents that will enable SCCH to focus their efforts and resources on the most significant health needs of the community.***

The goal of Quorum's CHNA process is to help SCCH determine priority health needs of the area and develop an implementation strategy for addressing those needs.

Project Objectives

SCCH partnered with Quorum Health Resources (Quorum) to:

- Complete a CHNA report
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Community Health Needs Assessment Subsequent to Initial Assessment

Quorum and SCCH followed an established process for the completion of the CHNA and implementation strategy. The goal of the CHNA process it to help the hospital determine the priority health needs of and area and develop and implementation strategy for addressing those needs. The SCCH CHNA report consists of the following information:

> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*

Additionally, all CHNAs developed after the very first CHNA received written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

The methodology takes a comprehensive approach to the solicitation of written comments. Input was obtained from the required three minimum sources and expanded input to include other representative groups. The Hospital asked all participating in the written comment solicitation process to self-identify themselves into any of the following

representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs. Perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.

Most data used in the analysis is available from public Internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating in this study are displayed in the CHNA report appendix.

Data sources include:

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Sullivan County compared to all Indiana counties	September 13, 2019	2012-2017
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of	September 16, 2019	2019

	each group in the entire area; and, to access population size, trends and socio-economic characteristics		
http://svi.cdc.gov	To identify the Social Vulnerability Index value	September 16, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	September 16, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	September 18, 2019	2017

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 15 Local Expert Advisors was received. Survey responses started October 24th, 2019 and ended on November 14th, 2019.
- Information analysis augmented by local opinions showed how Sullivan County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - The top three priority populations in the area are low-income groups, older adults and residents of rural areas
    - Unique and pressing needs:
        - Affordable and accessible care to the community
            - Transportation

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

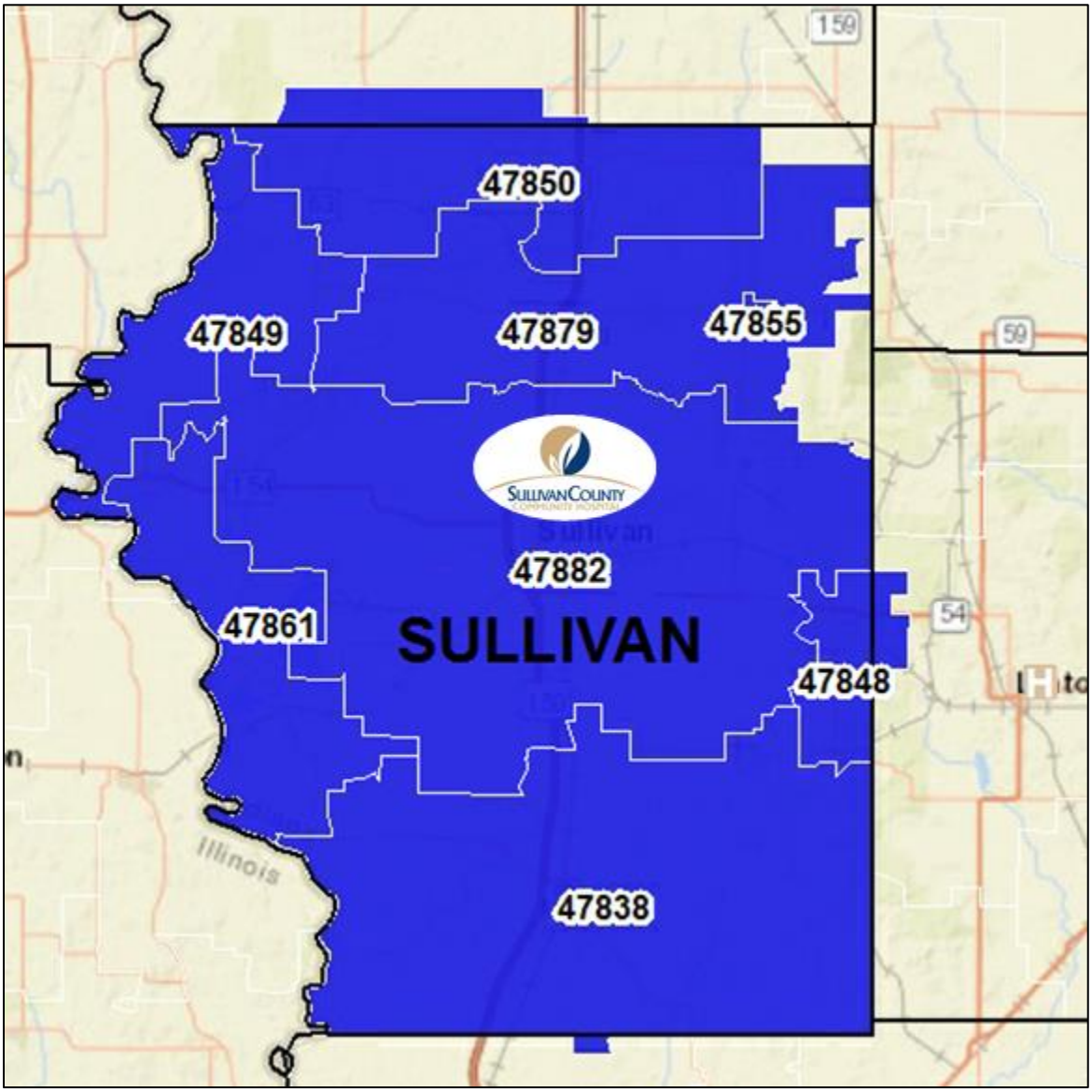
In the SCCH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the

opportunity to list additional needs that were not identified from the data.

The ranked needs were divided into two groups: “Significant” and “Other Identified Needs.” The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least sixty percent (60%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation where a reasonable break point in rank order occurred.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital



For the purposes of this study, Sullivan County Community Hospital defines its service area as Sullivan County and zip in Indiana, which includes the following ZIP codes:[2]

47838 – Carlisle	47848 – Dugger	47849 – Fairbanks	47850 – Farmersburg
47855 – Hymera	47861 – Merom	47879 – Shelburn	47882 – Sullivan

During 2018, the Hospital received 76.8% of its Medicare inpatients from this area.[3]

[2] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[3] IBM Watson Health MEDPAR patient origin data for the hospital

Demographics of the Community [4]

Variable	Sullivan County 2019	Sullivan County 2024	Sullivan County %Change	Indiana 2019	Indiana 2024	Indiana %Change	United States 2019	United States 2024	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	20,774	20,629	-0.7%	6,706,876	140,691	2.1%	329,236,175	340,950,067	3.6%
Total Male Population	11,257	11,162	-0.8%	3,306,916	71,177	2.2%	162,097,263	167,921,866	3.6%
Total Female Population	9,517	9,467	-0.5%	3,399,960	69,514	2.0%	167,138,912	173,028,201	3.5%
Females, Child Bearing Age (15-44)	3,288	3,163	-3.8%	1,301,753	11,388	0.9%	64,251,309	65,231,610	1.5%
Average Household Income	$58,452			$76,268			$89,646		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	3,403	3,378	-0.7%	1,293,451	-11,007	-0.9%	61,258,096	61,645,382	0.6%
15-17	756	736	-2.6%	272,562	5,851	2.1%	12,813,020	13,319,388	4.0%
18-24	1,818	1,822	0.2%	685,335	20,584	3.0%	31,474,821	32,296,411	2.6%
25-34	2,860	2,801	-2.1%	853,716	-2,871	-0.3%	44,370,805	43,645,423	-1.6%
35-54	5,462	5,137	-6.0%	1,658,448	-25,566	-1.5%	83,304,733	84,255,193	1.1%
55-64	2,739	2,635	-3.8%	871,255	-12,991	-1.5%	42,525,512	43,333,585	1.9%
65+	3,736	4,120	10.3%	1,072,109	166,691	15.5%	53,489,188	62,454,685	16.8%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	7,666	7,664	0.0%	2,596,538	57,721	2.2%	125,018,838	129,683,911	3.7%
2019 Household Income									
<$15K	1,184			268,891			13,139,420		
$15-25K	981			252,196			11,333,086		
$25-50K	1,845			631,582			26,888,001		
$50-75K	1,413			483,251			21,157,116		
$75-100K	986			339,796			15,409,735		
Over $100K	1,257			620,822			37,091,480		
EDUCATION LEVEL									
Pop Age 25+	14,797			4,455,528			223,690,238		
2019 Adult Education Level Distribution									
Less than High School	470			168,024			12,173,720		
Some High School	1,538			351,097			16,245,471		
High School Degree	6,279			1,511,304			61,068,735		
Some College/Assoc. Degree	4,595			1,296,179			64,945,355		
Bachelor's Degree or Greater	1,915			1,128,924			69,256,957		
RACE/ETHNICITY									
2019 Race/Ethnicity Distribution									
White Non-Hispanic	19,079			5,273,127			197,594,684		
Black Non-Hispanic	917			631,504			40,877,627		
Hispanic	399			481,647			60,675,779		
Asian & Pacific Is. Non-Hispanic	62			164,322			19,327,168		
All Others	317			156,276			10,760,917		

[4] Claritas (accessed through IBM Watson Health)

Consumer Health Service Behavior[5]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where SCCH's service area varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	118.3%	36.1%
Vigorous Exercise	92.1%	52.6%
Chronic Diabetes	108.0%	16.9%
Healthy Eating Habits	94.4%	22.0%
Ate Breakfast Yesterday	94.5%	74.8%
Slept Less Than 6 Hours	125.3%	17.1%
Consumed Alcohol in the Past 30 Days	81.5%	43.8%
Consumed 3+ Drinks Per Session	113.9%	32.1%
Behavior		
Search for Pricing Info	84.6%	22.8%
I am Responsible for My Health	99.9%	90.3%
I Follow Treatment Recommendations	102.2%	78.6%
Pulmonary		
Chronic COPD	139.2%	7.5%
Chronic Asthma	106.4%	12.6%
Heart		
Chronic High Cholesterol	109.5%	26.8%
Routine Cholesterol Screening	93.5%	41.5%
Chronic Heart Failure	154.4%	6.3%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Cancer Screen: Skin 2 yr	75.3%	8.1%
Cancer Screen: Colorectal 2 yr	91.2%	18.7%
Cancer Screen: Pap/Cerv Test 2 yr	81.9%	39.5%
Routine Screen: Prostate 2 yr	85.5%	24.3%
Orthopedic		
Chronic Lower Back Pain	115.1%	35.5%
Chronic Osteoporosis	128.2%	13.0%
Routine Services		
FP/GP: 1+ Visit	102.4%	83.4%
NP/PA Last 6 Months	104.4%	43.3%
OB/Gyn 1+ Visit	89.6%	34.5%
Medication: Received Prescription	105.2%	62.6%
Internet Usage		
Use Internet to Look for Provider Info	79.9%	31.9%
Facebook Opinions	81.4%	8.2%
Looked for Provider Rating	78.1%	18.3%
Emergency Services		
Emergency Room Use	109.6%	38.1%
Urgent Care Use	91.2%	30.1%

[5] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of SCCH's service area to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 18% more likely to have a **BMI of Morbid/Obese**, affecting 36%
- 8% less likely to **Vigorously Exercise**, affecting 53%
- 6% less likely to have **Ate Breakfast Yesterday**, affecting 75%
- 14% more likely to **Consume 3+ Drinks per Session**, affecting 32%
- 7% less likely to receive **Routine Cholesterol Screenings**, affecting 42%
- 18% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 40%
- 15% more likely have **Chronic Lower Back Pain**, affecting 36%
- 10% less likely to receive **Routine Ob/Gyn Visit**, affecting 35%
- 10% more likely to **Visit the Emergency Room (for non-emergent issues)**, affecting 38%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 19% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 44%

Leading Causes of Death[6]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Indiana's Top 15 Leading Causes of Death are listed in the table below in Sullivan's rank order. Sullivan's was compared to all other Indiana's, Indiana state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in IN (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation* (Sullivan County Compared to U.S.)
IN Rank	Sullivan Rank	Condition		IN	Sullivan	
1	1	Heart Disease	3 of 92	183.2	277.0	Higher than expected
2	2	Cancer	3 of 92	169.9	217.2	Higher than expected
3	3	Lung	20 of 92	55.1	62.5	Higher than expected
5	4	Stroke	28 of 92	40.1	54.3	Higher than expected
4	5	Accidents	18 of 92	58.7	53.0	As expected
6	6	Alzheimer's	3 of 92	35.2	46.9	Higher than expected
7	7	Diabetes	27 of 92	26.6	29.3	Higher than expected
8	8	Kidney	26 of 92	18.5	21.1	Higher than expected
11	9	Flu - Pneumonia	18 of 92	13.7	21.0	Higher than expected
10	10	Suicide	1 of 92	16.3	20.7	Higher than expected
9	11	Blood Poisoning	14 of 92	16.4	16.0	Higher than expected
12	12	Liver	32 of 92	11.5	8.9	As expected
13	13	Hypertension	29 of 92	10.2	8.0	As expected
14	14	Parkinson's	75 of 92	9.5	5.6	As expected
15	15	Homicide	26 of 92	7.1	3.4	As expected

**County Death Rate Observation: Higher than expected = 5 or more deaths per 100,000 compared to the US; Lower than expect = 5 or more less deaths per 100,000 compared to the US*

[6] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[7]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. The Hospital's approach is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

Begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of the Hospital's health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[8]

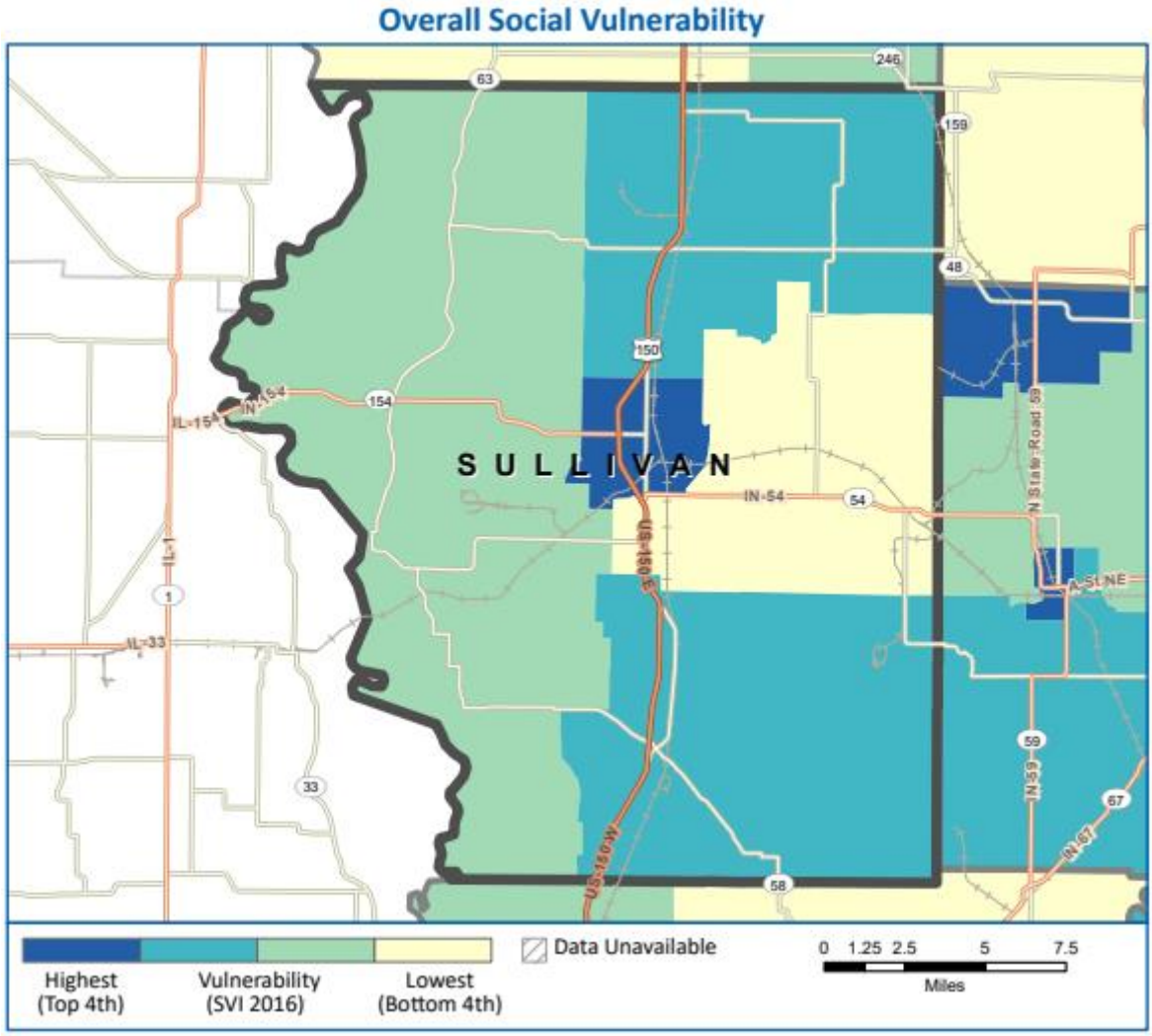
- The top three priority populations in the area are low-income groups, older adults and residents of rural areas
- Unique and pressing needs:
    - Affordable and accessible care to the community
        - Transportation

[7] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[8] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[9]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks.

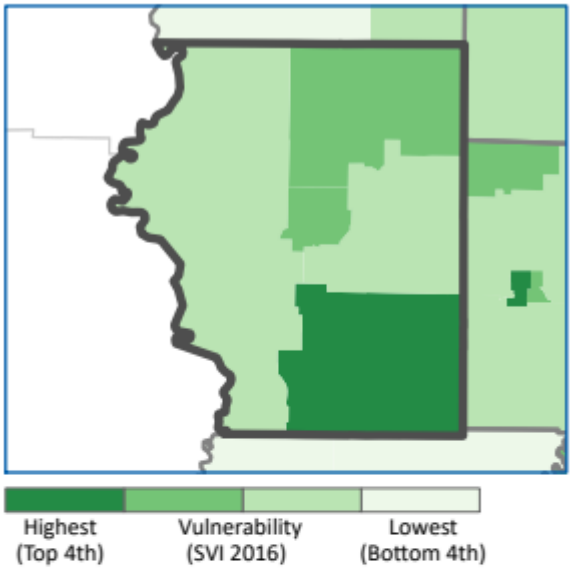
Based on the overall social vulnerability, Sullivan County falls into all four quartiles of social vulnerability. The majority of the county falls into the second lowest (light green) and the second highest (light blue) quartile. The right central region of the county in light yellow has the lowest social vulnerability, while the central region has the highest in dark blue.



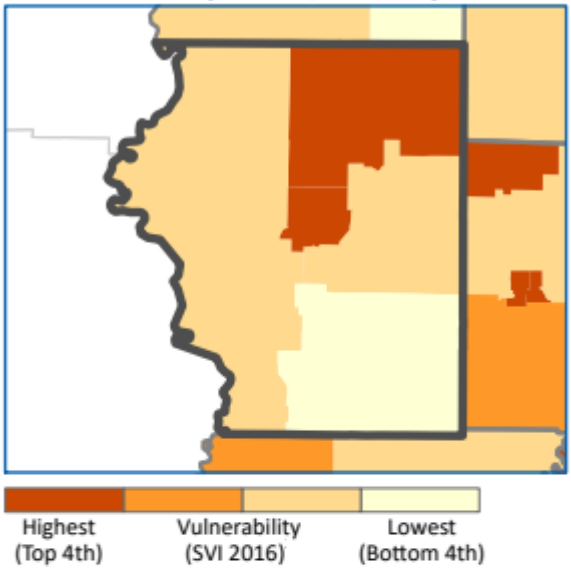
[9] http://svi.cdc.gov

SVI Themes

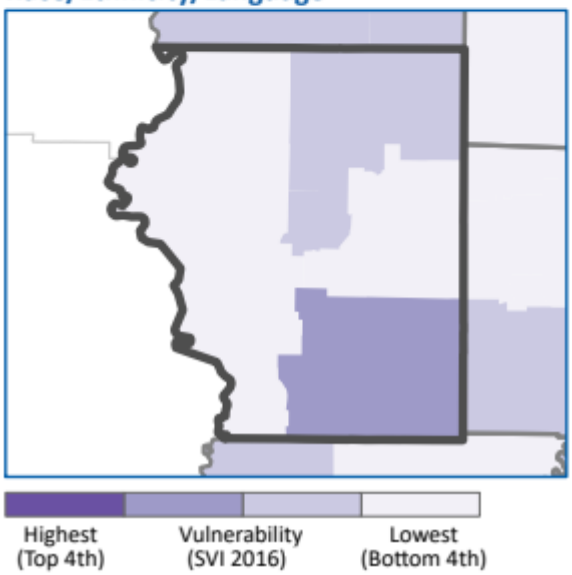
Socioeconomic Status



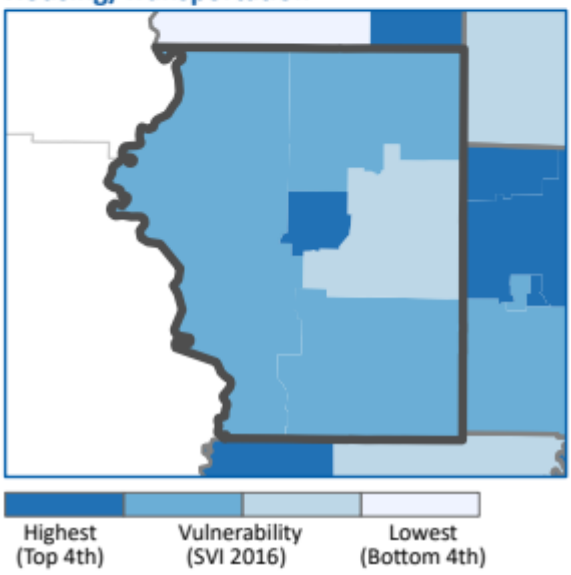
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to Other State Counties[10]

To better understand the community, Sullivan County has been compared to all 92 counties in the state of Indiana across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

In the chart below, the county's rank compared to all counties is listed along with measures in each area compared to the state average and U.S. Median.

	Sullivan	Indiana	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	**75/92**		
- Premature Death*	9,800	8,200	8,100
Quality of Life			
Overall Rank *(best being #1)*	**63/92**		
- Poor or Fair Health	18%	18%	17%
- Poor Physical Health Days Reported in Past 30 Days (average)	4.1	3.9	3.9
- Poor Mental Health Days Reported in Past 30 Days (average)	4.2	4.3	3.9
- Low Birthweight	7%	8%	8%
Health Behaviors			
Overall Rank *(best being #1)*	**76/92**		
- Adult Smoking	21%	21%	17%
- Adult Obesity	33%	33%	32%
- Physical Inactivity	31%	25%	26%
- Access to Exercise Opportunities	50%	75%	66%
- Excessive Drinking	17%	19%	17%
- Alcohol-Impaired Driving Deaths	33%	21%	28%
- Sexually Transmitted Infections*	229.4	466.0	321.7
- Teen Births *(per 1,000 female population ages 15-19)*	41	28	31
Clinical Care			
Overall Rank *(best being #1)*	**87/92**		
- Uninsured	9%	9%	10%
- Population to Primary Care Provider Ratio	1,730:1	1,500:1	2,050:1
- Population to Dentist Ratio	4,150:1	1,810:1	2,450:1
- Population to Mental Health Provider Ratio	2.960:1	670:1	970:1
- Preventable Hospital Stays	6,944	5,023	4,648
- Mammography Screening	27%	40%	40%
- Flu vaccinations	40%	47%	42%
Social & Economic Factors			
Overall Rank *(best being #1)*	**88/92**		
- Unemployment	4.4%	3.5%	4.4%
- Children in Poverty	19%	18%	21%
- Income Inequality**	5.2	4.4	4.4
- Children in Single-Parent Households	32%	34%	32%
- Violent Crime*	128	385	205
- Injury Deaths*	83	74	82
Physical Environment			
Overall Rank *(best being #1)*	**71/92**		
- Air Pollution - Particulate Matter	11.5 µg/m³	11.8 µg/m³	9.2 µg/m³
- Severe Housing Problems***	14%	14%	14%

Per 100,000 Population

****Ratio of household income at the 80th percentile to income at the 20th percentile***

*****Severe housing problems = overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities***

[10] www.countyhealthrankings.org

Conclusions from Other Statistical Data[11]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Sullivan County statistics to the U.S. average, as well as the trend in each measure over a 34-year span.

Sullivan County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Sullivan County measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Tracheal, Bronchus, and Lung Cancer*	60.4	80.0%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	65.4	33.2%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	75.9	40.2%
- Female Self-Harm and Interpersonal Violence Related Deaths*	12.8	61.6%
- Male Self-Harm and Interpersonal Violence Related Deaths*	40.7	27.6%
- Female Mental and Substance Use Related Deaths*	12.9	1201.7%
- Male Mental and Substance Use Related Deaths*	20.2	581.8%
UNFAVORABLE Sullivan County measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Female Life Expectancy	78.4	3.1%
- Male Life Expectancy	73.5	5.4%
- Female Heart Disease*	181.3	-38.0%
- Male Heart Disease*	282.8	-48.6%
- Female Stroke*	56.2	-60.3%
- Male Stroke*	63.5	-55.5%
- Male Tracheal, Bronchus, and Lung Cancer*	114.7	-10.0%
- Female Breast Cancer*	31.1	-20.1%
- Female Transport Injuries Related Deaths*	14.5	-19.5%
- Male Transport Injuries Related Deaths*	30.2	-34.5%
DESIRABLE Sullivan County measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
- Female Liver Disease Related Deaths*	9.8	4.1%
DESIRABLE Sullivan County measures that are **BETTER** than the US average and had a **FAVORABLE** change		
N/A		
AVERAGE Sullivan County measures that are **EQUAL** to the US average and had an **UNFAVORABLE** change		
- Male Breast Cancer*	0.4	4.6%
- Female Skin Cancer*	2.3	0.6%
- Male Skin Cancer*	5.1	51.1%
- Male Liver Disease Related Deaths*	22.8	32.6%
AVERAGE Sullivan County measures that are **EQUAL** to the US average and had a **FAVORABLE** change		
N/A		

*rate per 100,000 population, age-standardized

[11] http://www.healthdata.org/us-county-profiles

Community Benefit

Community benefit activities or programs seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2018) included:

- Community education hours provided by SCCH:
    - Q1 2019: 770.5
    - Q2 2019: 581.5
    - Q3 2019: 606.0
    - Q4 2019: 626.0

IMPLEMENTATION STRATEGY

Significant Health Needs

The methodology used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by SCCH. The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies SCCH current efforts responding to the need including any written comments received regarding prior SCCH implementation actions
- Establishes the Implementation Strategy programs and resources SCCH will devote to attempt to achieve improvements
- Documents the Leading Indicators SCCH will use to measure progress
- Presents the Lagging Indicators SCCH believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, SCCH is the major hospital in the service area. SCCH is a 25-bed, critical access hospital located in Sullivan, Indiana. The next closest facilities are outside the service area and include:

- Terre Haute Regional Hospital in Terre Haute, IN, 22 miles (29 minutes)
- Greene County General Hospital in Linton, IN, 21 miles (34 minutes)
- Union Hospital, Terre Haute, IN, 26.1 miles (37 minutes)
- Good Samaritan Hospital, Vincennes, IN, 34.9 miles (42 minutes)

All statistics analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the SCCH Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

1. **CANCER – Local expert concern; Sullivan County's mammography screening rate is worse than state average and US median; Sullivan County's smoking rate is worse than US median; Residents of Sullivan County are less likely to have routine cervical cancer screenings compared to the US median; Cancer is the #2 leading cause of death in Sullivan county**

Public comments received on previously adopted implementation strategy:

This was not a significant health need in 2016, so no comments were solicited.

SCCH services, programs, and resources available to respond to this need include:

- Hired a new OB/Gyn
- Clinics are now having a greater impact in the schools by now offering biometric screenings and wellness coaching to school employees
- New CT scanner offers lung cancer screenings
- Offer mammography screening specials in the month of October to promote Breast Cancer Awareness
- Breast and Cervical Cancer Program (BCCP) provides funding for breast and cervical cancer screenings services – screening services are contracted through Indiana medical providers and include clinical breast examinations, mammograms, and pap tests for eligible participants, as well as diagnostic testing for participants whose screening outcome is abnormal
- Access to health navigator
- Funds are available through business donations for breast cancer patients who are unable to pay
- Care coordinator services available
- Participate in the local health fairs
- Participate in Sullivan County Cares Cancer Walk, proceeds stay in Sullivan to assist patients from Sullivan County fighting cancer
- Social media, television, radio, and newspaper promotes education around cancer prevention
    - Women's health event – ties in cervical cancer and mammography screenings
- Smoking cessation classes were implemented after previous CHNA plan, but had some struggle with community participation after local educator left SCCH – SCCH looking into options to continue offering classes

Additionally, SCCH plans to take the following steps to address this need:

- Advancing to a 3-d mammography machine within the next three years
- Look into offering a men's health event around prostate cancer providing PSA testing at reduced rates
- Employer clinics offered to some of the largest employers in the county, including preventative services and

access to wellness coaches

Anticipated results from SCCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate SCCH intended actions is to monitor change in the following Leading Indicator:

- Mammography rate
- Cervical rate
- PSA rate
- Lung cancer screening rate

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Cancer death rate = 217.2 per 100,000 population (Sullivan, Indiana)[12]

SCCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
School corporations		

[12] Worldlifeexpectancy.com. Age-adjusted. 2017.

Organization	Contact Name	Contact Information
Sunrise Coal		12661 N Agri Care Rd, Oaktown, IN 47561 (812) 745-2920 http://sunrisecoal.com/
Bear Run/Peabody Coal		
Sullivan County Health Department		21 S Main St, Sullivan, IN 47882 (812) 268-0224

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
PACE Community Action Agency, Inc.		204 West Eaton Street, Carlisle, IN 47838 (812) 398-3851

2. **OBESITY/OVERWEIGHT – 2016 Significant Need; Sullivan County's adult obesity rate is worse than the US median; Sullivan County's physical inactivity and access to exercise opportunities rates are worse than the state average and US median; Residents of Sullivan County are less likely to vigorously exercise compared to the US average; Diabetes is the #7 leading cause of death in Sullivan County**

7. **PHYSICAL INACTIVITY – 2016 Significant Need; Sullivan County's adult obesity rate is worse than the US median; Sullivan County's physical inactivity and access to exercise opportunities rates are worse than the state average and US median; Residents of Sullivan County are less likely to vigorously exercise compared to the US average**

Due to the similar actions required to address these needs, a single implementation strategy has been developed.

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

SCCH services, programs, and resources available to respond to this need include:

- Fitness Center – open to the public seven days a week offering fitness classes, weight room, cardio center, indoor track
    - Offer Kids fitness class twice a week
    - 12-week weight loss challenge
    - Diabetic exercise program with blood sugar monitoring and dietary education
    - Corporate membership offered to hospital employees and families, schools, and local businesses; free childcare available
    - Hospital gave away free trial memberships at local events
    - Personal training for local athletes
    - Soccer Clinic and Sports Enhancement Program, Weight Management Program, Kid and Senior programming
    - Employee Fitness Class provided four days a week for nominal fee (membership not required)
    - Increased access to fitness center
    - Expanded hours
    - Wellness coaching offered
    - Personal training offered
- Hosted a holiday mile run
- Hospital athletic trainer provided at local sporting events
- Offer employer clinics to local school districts including wellness coaching for 16 hours per week

- Community Wellness Council made up of local employers and advocate groups that work together to address Smoking, Heart Attack/Cardiovascular Disease, and Obesity, and to build awareness of issues and activities
    - Halloween Mile Walk, Open Square Activity (close town square to traffic to allow for walking and other activities)
- Hospital provides Meals on Wheels program to Sullivan County residents for a nominal fee that includes lunch and dinner; delivered by volunteer program
- Weight Watchers program available on campus
- Registered dietician dietary inpatient consults and hosts diabetic adult and juvenile education classes
- Employer and community health fairs that include free screenings for BMI, blood pressure, and blood glucose
- "Move It to Lose It" weight-loss challenge offered twice per year to employees and spouses
- Free fruit provided in hospital cafeteria and available to employees and family, and provide healthy options including fewer desserts and lower calorie/fat snacks
- Hospital offers fresh produce delivery program for employees for a small fee
- Hospital provides free BMI screens, lipid panels, A1C, blood pressure, height & weight, and liver function tests to employees and spouses
- Support Brown Baggers program that provides bags of food to students to take home over the weekend; includes raising money and food drives
- Donate to Our Father's Arms food pantry
- Contribute to Salvation Army's shoe collection program to provide shoes to kids in need
- Hospital participates in Better Health Wabash Valley (formed after 2013 CHNA) to help address area health needs; program brings in grant money to help address specific issues

Additionally, SCCH plans to take the following steps to address this need:

- Investigate ways to partner more closely with schools to provide wellness education
- Look into relaunching Fit Kids Program – offered three times per year to provide activity day-camp to kids

SCCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Implemented wellness clinic (Be Healthy) for hospital employees and spouses that includes free labs including Lipid Panel, A1C, kidney and liver function, and includes wellness coaching; providing free memberships to the fitness center for all department directors
- Added RN Care Coordinator through ACO program to develop chronic care management program
- Employee lunch and learns that are centered around obesity/overweight/exercise/nutrition
- Fitness center launched their own website providing information for users on memberships, classes, etc.

- Added Silver Sneakers
- Hosted a holiday mile run
- Increased access to fitness center
- Expanded hours at fitness center
- Wellness coaching offered
- Personal training offered
- Offer Kids fitness class twice a week

Anticipated results from SCCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate SCCH intended actions is to monitor change in the following Leading Indicator:

- Number of Fitness Center members

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Adult Obesity Rate = 33% (Sullivan, Indiana)[13]

[13] County Health Rankings. Percentage of adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/mg. 2015.

SCCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Remove pool from collaborators		
Better Health Wabash Valley	Becky Edwards	Terre Haute Chamber of Commerce (812) 232-2391 https://terrehauteincoc.wliinc24.com/live-and-work/better-health-wabash-valley.aspx
Sullivan Wellness Council (Milburn's Pharmacy, Purdue Extension Service, Sullivan School Corporation, Wellness Chiropractic, First Financial Bank, Springer Insurance, Public Library, Sullivan Daily Times Newspaper, City of Sullivan, Sullivan County Community Hospital, SCCH Fitness Center, Hamilton Center	Leslie Lentz	(317) 264-2168 info@wellnessindiana.org https://www.wellnessindiana.org/
Local school districts	Chris Stitzle, Southwest School Corp. Mark Baker, Northeast Schools	
Local employers		
Brown Baggers	Israel Brewer, President	https://www.facebook.com/groups/BrownBaggerSchoolFoodProgram/
Salvation Army	Marjorie Bray	502 N Section Street, Sullivan, IN (812) 691-8174

3. **DIABETES – 2016 Significant Need; Sullivan County's adult obesity rate is worse than the US median; Sullivan County's physical inactivity and access to exercise opportunities rates are worse than the state average and US median; Residents of Sullivan County are less likely to vigorously exercise compared to the US average; Diabetes is the #7 leading cause of death in Sullivan County**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

SCCH services, programs, and resources available to respond to this need include:

- Implemented Medicare Annual Wellness Visit Campaign to encourage community participation
- Fitness Center – open to the public seven days a week offering fitness classes, weight room, cardio center, indoor track
    - Offer Kids fitness class twice a week
    - 12-week weight loss challenge
    - Diabetic exercise program with blood sugar monitoring and dietary education
    - Corporate membership offered to hospital employees and families, schools, and local businesses; free childcare available
    - Hospital gave away free trial memberships at local events
    - Personal training for local athletes
    - Soccer Clinic and Sports Enhancement Program, Weight Management Program, Kid and Senior programming
    - Employee Fitness Class provided four days a week for nominal fee (membership not required)
    - Increased access to fitness center
    - Expanded hours
    - Wellness coaching offered
    - Personal training offered
- Offer employer clinics to local school districts including wellness coaching for 16 hours per week, and provide generic medications at a reduced cost to increase compliance
- Hospital provides Meals on Wheels program to Sullivan County residents for a nominal fee that includes lunch and dinner; delivered by volunteer program
- Registered dietician on staff that provides dietary consults and hosts diabetic adult and juvenile education classes
- Employer and community health fairs that include free screenings for BMI, blood pressure, and blood glucose

- Free fruit provided in hospital cafeteria and available to employees and families, and provide healthy options including fewer desserts and lower calorie/fat snacks – Free fruit only offered to employees
- Hospital offers fresh produce delivery program for employees for a small fee
- Hospital provides free BMI screens, lipid panels, A1C, blood pressure, height weight, liver function tests to employees and spouses
- Support Brown Baggers program that provides bags of food to students to take home over the weekend; includes raising money and food drives
- Implemented in-house pharmacy program for employees and families to get medicines at a deeply discounted rate and increase compliance
- Implemented juvenile diabetes support group that is hosted and led by the hospital
- Hospital provides free glucometers to newly diagnosed patients
- Coordinating with other facilities/providers to provide additional resources (e.g., strips and lancets) to local patients
- Weight Watchers program available on campus

Additionally, SCCH plans to take the following steps to address this need:

- Looking at other vendors to partner with on providing wellness education to schools
- Explore opportunity for education to certify a diabetic educator

SCCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Implemented wellness clinic (Be Healthy) for hospital employees and spouses that includes free labs including Lipid Panel, A1C, kidney and liver function, and includes wellness coaching; providing free memberships to the fitness center for all department directors
- Added RN Care Coordinator through ACO program to develop chronic care management program
- Employee lunch and learns that are centered around obesity/overweight/exercise/nutrition
- Offer direct access to lab testing

Anticipated results from SCCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers		

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate SCCH intended actions is to monitor change in the following Leading Indicator:

- Hemoglobin A1Cs
- Number of nutrition counseling/education visits for diabetes and/or obesity

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Diabetes death rate = 29.3 per 100,000 population (Sullivan, Indiana)[14]

SCCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
American Diabetes Association	Carol Dixon, Regional Director, Community Health Strategies cdixon@diabetes.org	indiana@diabetes.org

[14] Worldlifeexpectancy.com. Age-adjusted. 2017.

Organization	Contact Name	Contact Information
Sullivan Wellness Council (Milburn's Pharmacy, Purdue Extension Service, Sullivan School Corporation, Wellness Chiropractic, First Financial Bank, Springer Insurance, Public Library, Sullivan Daily Times Newspaper, City of Sullivan, Sullivan County Community Hospital, SCCH Fitness Center, Hamilton Center	Leslie Lentz	(317) 264-2168 info@wellnessindiana.org https://www.wellnessindiana.org/
Indiana Organization of Nurse Executives	Rhonda Smith	(317) 423-7731 500 N Meridian St #250, Indianapolis, IN 46204 www.indianaone.org
Better Health Wabash Valley	Becky Edwards	Terre Haute Chamber of Commerce (812) 232-2391 https://terrehauteincoc.wliinc24.com/live-and-work/better-health-wabash-valley.aspx

4. **DRUG/SUBSTANCE ABUSE – 2016 Significant Need; Sullivan County's female and male mental and substance use related death rate were worse than the US average in 2014 and saw an increase from 1980-2014 (female: 1201.7%; male: 581.8%)**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

SCCH services, programs, and resources available to respond to this need include:

- Initiated a Pain Management Service Line to encourage interventional treatments over medications
    - Patients prescribed narcotics receive a referral to Hamilton Center for counseling to help avoid addiction
- Worked with Communities that Care for resources for website and providers to educate on drug use and suicide
- Partner with local sheriff's department and Communities that Care to participate in medication take-back day
- Provide tele-mental health program for patients who present with drug or mental health issues
- Provide drug testing services for local employers and have increased awareness of testing availability
- Provided education to physicians on new prescribing guidelines

Additionally, SCCH plans to take the following steps to address this need:

- Adding a social worker to Care Coordination to be a bridge between patients and community resources
- Working on opportunity for joint program with Hamilton Center, CPS, and OB providers to provide programming for expectant mothers with substance abuse issues
- Explore options of offering a MAT program

SCCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Added RN Care Coordinator through ACO program to develop chronic care management program
- Received grant through United Way to combat opioid use in rural counties through substance use disorder council planning consortium – started in October 2019
- Refer patients to the Hamilton Center when necessary for addiction services – potentially additional collaboration efforts in the future
- Support the Ruth House women in recovery program through financial support, SCCH board membership presence, etc.
- Implemented a Perinatal Navigator Program to work closely with expectant moms for guidance and support focusing on a safe and healthy pregnancy for mother and baby
- Implemented Turning Leaf Behavioral Health program for senior citizen, an intensive structured outpatient

therapy program to help seniors transition through late adulthood

Anticipated results from SCCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities		X
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate SCCH intended actions is to monitor change in the following Leading Indicator:

- Number of participants in Turning Leaf Program (QHR Example)
- Number of participants in Perinatal Navigator Program (QHR Example)
- Outcome of MAT Program – if this happens (QHR Example)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Drug Overdose Deaths

SCCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Wabash Valley Telehealth Network		Union Hospital 1433 N. 6 1/2 Street, Terre Haute, IN 47807 (812) 238-7479 www.ruraltelenet.org

Organization	Contact Name	Contact Information
Hamilton Center	Mel Burkes	2134 Mary Sherman Dr., Sullivan, IN 47882 (812) 268-6376 www.hamiltoncenter.org
Indiana Perinatal Network – Neonatal Abstinence Syndrome Program		1991 E. 56th St., Indianapolis, IN 46220 (866) 338-0825 www.indianaperinatal.org
Ruth House	Melody Loveless	128 S Crowder St, Sullivan, IN 47882 (812) 268-3728 https://www.facebook.com/The-Luke-House-12184570599/?rf=607088846099421

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Local AA Groups		Wabash Valley Intergroup (812)236-2369 www.terrehauteaa.com Southwestern Indiana Central (800)266-5584 www.southwesternindianaaa.org
Local NA Groups		WVASC, P.O. Box # 9543, Terre Haute, IN, 47808 (877) 888-4130 http://www.naindiana.org
Sullivan County Prosecutor	John Springer	100 Court House Sq # 303, Sullivan, IN, 47882 (812) 268-6008 www.sullivancountyprosecutor.com

5. **HEART DISEASE – 2016 Significant Need; Residents of Sullivan County are less likely to receive routine cholesterol screenings compared to the US average; Heart disease is the #1 leading cause of death in Sullivan County**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

SCCH services, programs, and resources available to respond to this need include:

- Cardio-pulmonary rehab program available to patients who have had a cardiac event or who have all the risk factors for an event; includes monitored exercise, nutrition education, and medication; requires doctor's orders
- Provide free echocardiogram to Sullivan County student athletes
- Discounted sports physicals provided to local student athletes
- Hospital offers community CPR classes
- Hospital received grant to place 20 AEDs in community locations, and taught CPR to 1,006 people (577 students) in first year and 502 (426 students) in second year (2014-2016)
- Contracts with Lincare Continuum to provide a 30-day in-home education program for just-released cardiac patients
- Free triglyceride tests available to employees and spouses annually
- Implementing wellness clinic (Be Healthy) for hospital employees and spouses that will include free labs (Lipid Panel, A1C, kidney and liver function) and wellness coaching; providing free membership to the fitness center to all department directors
- Implemented Medicare Annual Wellness Visit Campaign to encourage community participation

SCCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Participated in Million Hearts Program through CMS that will study a group of patients over three years to monitor risk factors and watch for changes in cardiac health

SCCH does not intend to develop an implementation strategy for this Significant Need

SCCH is choosing not to respond to this need. SCCH recognizes the importance of this need, however, SCCH feels SCCH can have a greater impact by putting attention and resources toward other significant needs for which are better qualified to serve.

Classifications of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need

1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	**X**

6. **MENTAL HEALTH – Local expert concern; Residents of Sullivan County reported more poor mental health days in the past 3 days compared to the US median on average; Sullivan County's population to mental health provider ratio is worse than the state average and US median; Suicide is the #10 leading cause of death in Sullivan County**

SCCH services, programs, and resources available to respond to this need include:

- Provide tele-mental health program for patients who present with drug or mental health issues
- Implemented Turning Leaf Behavioral Health program for senior citizen, an intensive structured outpatient therapy program to help seniors transition through late adulthood
- Support the Ruth House women in recovery program through financial support, SCCH board membership presence, etc.
- Worked with Communities that Care for resources for website and providers to educate on drug use and suicide

SCCH does not intend to develop an implementation strategy for this Significant Need

SCCH is choosing not to respond to this need. SCCH recognizes the importance of this need, however, SCCH feels SCCH can have a greater impact by putting attention and resources toward other significant needs for which are better qualified to serve.

Classifications of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	**X**
5. Need is addressed by other facilities or organizations in the community	**X**

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Ruth House	Melody Loveless	128 S Crowder St, Sullivan, IN 47882 (812) 268-3728 https://www.facebook.com/The-Luke-House-12184570599/?rf=607088846099421

Organization	Contact Name	Contact Information
Local NA Groups		WVASC, P.O. Box # 9543, Terre Haute, IN, 47808 (877) 888-4130 http://www.naindiana.org
Hamilton Center	Mel Burkes	2134 Mary Sherman Dr., Sullivan, IN 47882 (812) 268-6376 www.hamiltoncenter.org

8. **EDUCATION/PREVENTION – Local expert concern; Sullivan County's mammography screening and flu vaccination rates are worse than the state average and US median; Preventable hospital stays is worse than the state average and US median; Premature death rate is worse than state average and US median**

Public comments received on previously adopted implementation strategy:

This was not a significant health need in 2016, so no comments were solicited.

SCCH services, programs, and resources available to respond to this need include:

- Clinics are now having a greater impact in the schools by doing biometric screenings and wellness coaching
- New CT scanner offers lung cancer screenings
- Offer mammography screening specials in the month of October to promote Breast Cancer Awareness
- Breast and Cervical Cancer Program (BCCP) provides funding for breast and cervical cancer screenings services – screening services are contracted through Indiana medical providers and include clinical breast examinations, mammograms, and Pap tests for eligible participants, as well as diagnostic testing for participants whose screening outcome is abnormal
- Participate in the local health fairs
- Social media, television, radio promotes education around cancer prevention
    - Women's health event – ties in cervical cancer and mammography screenings
- Smoking cessation classes were implemented after previous plan, but had some struggle with community participation after local educator left – SCCH looking into options to continue offering classes
- Fitness Center – open to the public seven days a week offering fitness classes, weight room, cardio center, indoor track
    - Offer Kids fitness class twice a week
    - 12-week weight loss challenge
    - Diabetic exercise program with blood sugar monitoring and dietary education
    - Corporate membership offered to hospital employees and families, schools, and local businesses; free childcare available
    - Hospital gave away free trial memberships at local events
    - Personal training for local athletes
    - Soccer Clinic and Sports Enhancement Program, Weight Management Program, Kid and Senior programming
    - Employee Fitness Class provided four days a week for nominal fee (membership not required)
    - Increased access to fitness center

    - Expanded hours
    - Wellness coaching offered
    - Personal training offered
- Registered dietician on staff that provides dietary consults and hosts diabetic adult and juvenile education classes
- Employer and community health fairs that include free screenings for BMI, blood pressure, and blood glucose
- Implemented in-house pharmacy program for employees and families to get medicines at a deeply discounted rate and increase compliance
- Weight Watchers program available on campus
- Employee lunch and learns that are centered around obesity/overweight/exercise/nutrition
- Offer direct access to lab testing
- Worked with Communities that Care for resources for website and providers to educate on drug use and suicide
- Implemented a Perinatal Navigator Program to work closely with expectant moms for guidance and support focusing on a safe and healthy pregnancy for mother and baby

Additionally, SCCH plans to take the following steps to address this need:

- Advancing to a 3-d mammography machine within the next three years
- Look into offering a men's health event around prostate cancer providing PSA testing at reduced rates
- Employer clinics offered to some of the largest employers in the county, including preventative services and access to wellness coaches
- Looking at other vendors to partner with on providing wellness education to schools
- Explore opportunity for education to certify a diabetic educator

SCCH does not intend to develop an implementation strategy for this Significant Need

SCCH is choosing not to respond to this need. SCCH recognizes the importance of this need, however, SCCH feels SCCH can have a greater impact by putting attention and resources toward other significant needs for which are better qualified to serve.

Classifications of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**

3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	**X**

Other Needs Identified During CHNA Process

9. **Affordability/Accessibility**
10. **Smoking/Tobacco Use – 2016 Significant Need**
11. **Write-in: Hunger in children and senior citizens**
12. **Alcohol abuse**
13. **Suicide**
14. **Alzheimer's**
15. **Stroke**
16. **Women's Health**
17. **Kidney Disease**
18. **Chronic Pain Management**
19. **Hypertension**
20. **Lung Disease**
21. **Respiratory Infections**
22. **Accidents**
23. **Flu/Pneumonia**
24. **Dental**
25. **Liver Disease**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility

1. Cancer
2. Obesity/Overweight – 2016 Significant Need
3. Diabetes – 2016 Significant Need
4. Drug/Substance Abuse – 2016 Significant Need
5. Physical Inactivity – 2016 Significant Need

Significant needs where hospital did not develop implementation strategy

1. Heart Disease – 2016 Significant Need
2. Mental Health
3. Education/Prevention

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

Hospital solicited written comments about its 2016 CHNA. 15 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	3	8	11
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	7	13
3) **Priority Populations**	4	6	10
4) Representative/Member of **Chronic Disease Group** or Organization	0	9	9
5) Represents the **Broad Interest of the Community**	12	1	13
Other			1
Answered Question			15
Skipped Question			0

Congress defines "Priority Populations" to include:

- Racial and ethnic minority groups
- Low-income groups
- Women
- Children
- Older Adults
- Residents of rural areas
- Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care
- Lesbian Gay Bisexual Transsexual (LGBT)
- People with major comorbidity and complications

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Transportation to and from appointments. Access to free food beyond once monthly*
- *Affordable of health care and access to services*
- *Not that I know of*
- *The pressing need of food stability, affordable medical care including ambulance transports and hospital occurrences, affordable prescription drugs and safe havens for abused/battered women and children.*

In the 2016 CHNA, there were six health needs identified as "significant" or most important:

1. **Obesity**
2. **Smoking**
3. **Physical Inactivity**
4. **Heart Disease**
5. **Diabetes**
6. **Substance Abuse**

3. Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2016 CHNA?

	Yes	No	Response Count
Obesity	14	0	14
Smoking	14	0	14
Physical Inactivity	14	0	14
Heart Disease	14	0	14
Diabetes	14	0	14
Substance Abuse	14	0	14

4. Please share comments or observations about the actions SCCH has taken to address <u>OBESITY</u>.

- *There is a large group of low-income families that cannot afford gym memberships or healthy food items. There is a great number of people who live in this community that live off of church donations and food banks. I think SCCH has done a great job of offering wellness services in the community and establishing our Care Coordination department. The outreach within this department is significant. I haven't seen a bicycle on campus but this would be a nice service to offer employees. We need to continue to keep a focus on low-income/under-served.*
- *Wellness group has hosted events encouraging movement and healthy eating.*
- *SCCH has done an outstanding job of promoting physical fitness. They have been involved in community action plans to fight obesity*
- *Some of these have been implemented to my knowledge*
- *I think the steps taken for employees and their spouses is great but I think we need to be thinking on a county wide basis. We need to get our entire county healthy.*
- *Wellness clinic has been one of the focus areas.*
- *Hospital should expand services provided by its fitness center and diet/food services so that more awareness can be raised in the community regarding the importance of exercise and healthy eating.*

5. Please share comments or observations about the actions SCCH has taken to address <u>SMOKING</u>.

- *Quit Now information has been shared by our Care Coordination department throughout all Clinics. The Wellness*

Clinic (Medicare) and CCM patients receive smoking cessation education at least once a year. Current efforts have been helpful. Education for providers and staff was helpful as most didn't realize IN Quit Now offered free resources. Education provided is tracked in the EHR and CCM care plans.

- *I know they have but I am not aware of any specific programs*
- *Uncertain of progress, I have not been pt at SCCH to determine implementation. I believe some of these goals have been met.*
- *Again, great job on what you're doing. I think getting the education out to the young people not to even start this disgusting habit is an essentially key component.*
- *Participates/partners with Sullivan Co. Health Coalition*
- *Hospital should increase smoking cessation services to fill gap left by closing of local pharmacy.*

6. Please share comments or observations about the actions SCCH has taken to address PHYSICAL INACTIVITY.

- *I would like to see bicycles on campus. This would beneficial for employees to use between clinic visits and transport back/forth from the hospital. The fitness center is beneficial for our community - my only concern is for the people who cannot afford to pay the monthly fee. What is required to participate in Silver Sneakers? Could we look at discussing a reduced rate for those who financially qualify? Having the gym in Sullivan County is beneficial to the community.*
- *Hosting fun runs/walks and other physically active activities. Providing the community with a well-equipped fitness center.*
- *SCCH has been very involved with the community in promoting fitness. Through the fitness center they have a wide variety of programs that are available to all age groups.*
- *Some of these have been implemented to my knowledge*
- *We need to put our phones, laptops and computers down and get moving! Maybe making the fitness center more affordable for patients with chronic conditions.*
- *They promote activities through the fitness center*
- *See above comments on "Obesity."*

7. Please share comments or observations about the actions SCCH has taken to address HEART DISEASE.

- *We opted out of Million Hearts due to extensive EHR reporting requirements. However, through our Care Coordination department, we educate patients on healthy diets, controlling blood pressure, medication management, importance of routine visits with providers and encourage physical activity. Exercise handouts (appropriate fitness level) are provided - this includes walking programs, chair bound exercises and stretches. Blood pressure and wellness visit screenings have been offered in the community at the hi-rises.*
- *I have seen publications and newspaper articles about what SCCH is doing to fight Heart Disease. They keep the surrounding communities informed about programs that are available through SCCH*

- *Unsure*
- *Education of the causes and affects of heart disease.*

8. Please share comments or observations about the actions SCCH has taken to address <u>DIABETES</u>.

- *Diabetes remains a prevalent concern in the community along with a host of other chronic diseases. The hospital offers lab screenings for well incentives for employees on the insurance here. Care Coordination outreach with diabetics is positive. Since establishing our Wellness Clinic (Medicare) we have seen an increase in RD referrals for ongoing patient education. SCCH's Education department offers beneficial community diabetic education classes.*
- *I know they are very involved with the individuals who are in need of medical assistance with diabetes.*
- *Some of these have been implemented to my knowledge*
- *Again, what you're doing is great but we need to address this on a much wider scale. This is a county wide problem. Maybe the implementation of support groups lead by a medical professional/dietitian?*

9. Please share comments or observations about the actions SCCH has taken to address <u>SUBSTANCE ABUSE</u>.

- *Established a formal Perinatal Navigation program through a partnership with IRHA. This program is geared at working with high risk mom's, dad's and babies. SCCH staff has met with Ruth House staff (local sober living house) and provides education to those at risk. Continue to work with Hamilton Center in the community. Care Coordination also follows high risk patients as referred to ensure ongoing continuity of care.*
- *They play a very active role in the community to fight substance abuse. They partner with the mental health organizations, schools and a variety of other organizations*
- *Unsure*
- *Great job here too.*

Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey Results)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Cancer	116	9	9.7%	9.7%	Significant Needs
Obesity/Overweight*	113	11	9.4%	19.1%	
Diabetes*	107	8	8.9%	28.0%	
Drug/Substance Abuse*	105	9	8.8%	36.8%	
Heart Disease*	90	9	7.5%	44.3%	
Mental Health	74	7	6.2%	50.4%	
Physical Inactivity*	60	6	5.0%	55.4%	
Education/Prevention	59	5	4.9%	60.3%	
Affordability/Accessibility	55	5	4.6%	64.9%	Other Identified Needs
Smoking/Tobacco Use*	55	6	4.6%	69.5%	
Write-in: Hunger in children and senior citizens	50	1	4.2%	73.7%	
Alcohol Abuse	45	6	3.8%	77.4%	
Suicide	44	6	3.7%	81.1%	
Alzheimer's	39	5	3.3%	84.3%	
Stroke	31	5	2.6%	86.9%	
Women's Health	30	5	2.5%	89.4%	
Kidney Disease	26	4	2.2%	91.6%	
Chronic Pain Management	21	4	1.8%	93.3%	
Hypertension	21	4	1.8%	95.1%	
Lung Disease	17	4	1.4%	96.5%	
Respiratory Infections	11	3	0.9%	97.4%	
Accidents	10	4	0.8%	98.3%	
Flu/Pneumonia	9	3	0.8%	99.0%	
Dental	8	3	0.7%	99.7%	
Liver Disease	4	3	0.3%	100.0%	

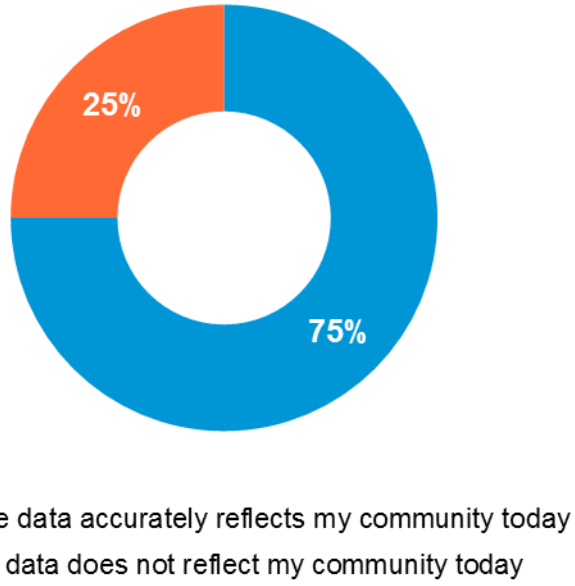
**= 2016 Significant Health Needs*

Individuals Participating as Local Expert Advisors

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	3	8	11
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	7	13
3) **Priority Populations**	4	6	10
4) Representative/Member of **Chronic Disease Group** or Organization	0	9	9
5) Represents the **Broad Interest of the Community**	12	1	13
Other			1
Answered Question			15
Skipped Question			0

Advice Received from Local Expert Advisors

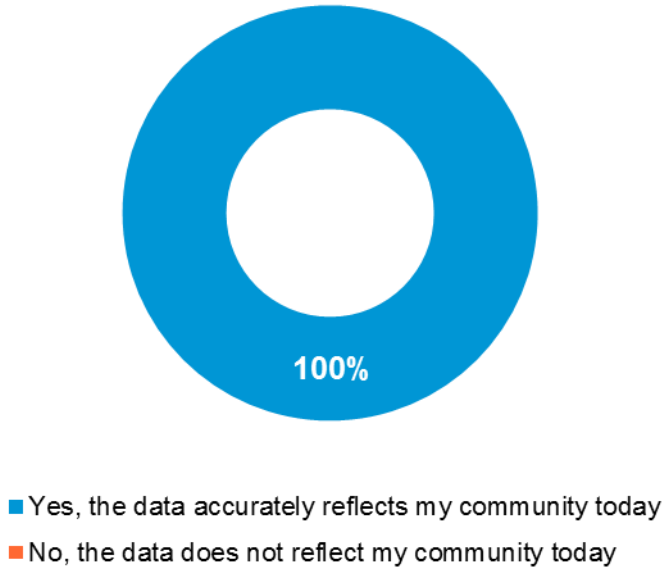
Question: Do you agree with the comparison of Sullivan County to all other Indiana counties?



Comments:

- *I think our community participation in flu vaccines and mammograms (as well as other preventive measures) has improved since establishing our Care Coordination department and ACO initiatives.*
- *I am not sure*
- *I feel the Indiana average in many areas is lower than our community. I feel our area has higher percentages in obesity, low income, and smoking. I believe our unemployment rate is actually lower than the state average currently.*
- *I think some of the Data is accurate, but I don't believe it is 100% reliable*
- *I think we have a higher poverty rate and drug abuse*

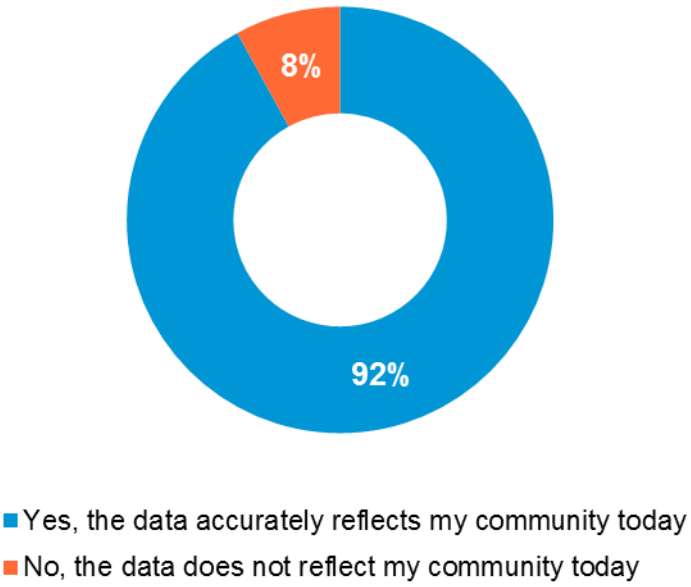
Question: Do you agree with the demographics and common health behaviors of SCCH's service area?



Comments:

- *I am not sure*

Question: Do you agree with the overall social vulnerability index for Sullivan County?



Comments:

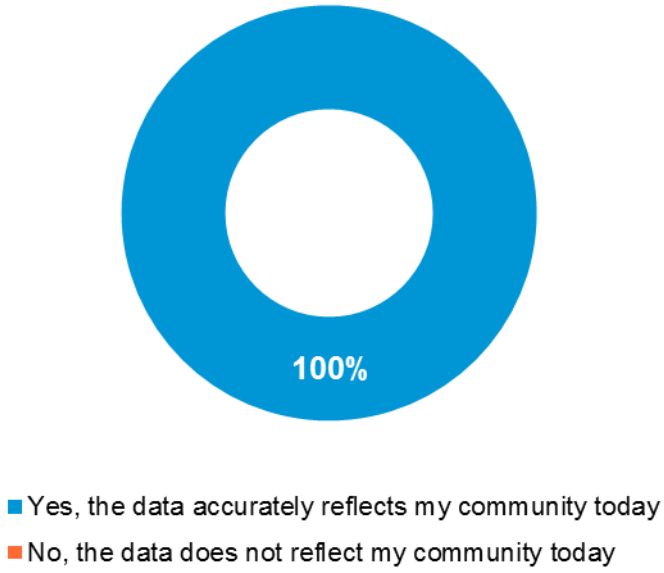
- *I am not sure*

Question: Do you agree with the national rankings and leading causes of death?

Comments:

- *N/A*

Question: Do you agree with the health trends in Sullivan County?



Comments:

- *I am not sure*

Appendix C – National Healthcare Quality and Disparities Report[15]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsured, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

Key Findings

Access: An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

[15] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

Quality: Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

Disparities: Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[16] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[16] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

Link to the full report:

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf